DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINT: 07/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445141	A. BUILDING _____ B. WING _____	R 07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADLEY HEALTH CARE & REHAB	2910 PEERLESS RD CLEVELAND, TN 37312

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{F 000}	INITIAL COMMENTS A revisit survey was completed on July 9, 2013 following acceptance of an Allegation of Compliance to remove the Immediate Jeopardy at F-323, F-490, F-501 and F-520, all with a Scope and Severity level "K". The revisit revealed the corrective actions implemented June 29, 2013 removed the Immediate Jeopardy, but non-compliance continues at a "E" level scope and severity for F-323, F-490, F-501 and F-520. The facility is required to submit a Plan of Correction for the Immediate Jeopardy citations lowered in scope and severity and for all of the lower level non jeopardy citations.	{F 000}		
{F 159} SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.	{F 159}	1. Resident # 34 expired on June 6, 2013. The account was closed to the estate on June 19, 2013. 2. An audit by the Business Office Manager of the trust fund accounts on July 15, 2013 revealed no other trust fund accounts exceeding the limit allowed by the department of human services. 3. A form letter (Attachment 1) will be routinely sent by the Patient Trust Representative to the responsible party when the trust fund account is approaching the limit allowed by the Department of Human Services. The staff will work with and assist the family in spending down the monies. 4. The Business Office Manager will conduct a monthly audit of resident trust fund accounts to ensure all accounts are within the balance limit allowed by the Department of Human Services. The Business Office Manager will report to the August QAPI Committee meeting any July outcomes of concern and monthly thereafter. Attachment 1: Form Letter - Notification of DHS Limit.	07/15/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 7/26/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 159}	Continued From page 1 The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act, and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of facility trust account ledger, patient trust accounts guidelines, and interview, the facility failed to notify residents and/or responsible parties of balances within two hundred dollars of the Social Security Income (SSI) resource limit for one resident (#34) of one hundred and thirty-one resident accounts reviewed.	{F 159}		

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{F 159}	Continued From page 2 The findings included: Review of the facility trust account ledger dated June 18, 2013, for resident #34 revealed the following balances: January, 2013: $15,255.65 February, 2013: $16,127.75 March, 2013: $17,307.68 April, 2013: $18,465.05 May, 2013: $19,676.74 June, 2013: $21,686.99 Continued review of facility documentation revealed the resident expired on June 6, 2013. Review of facility "Patient Trust Accounts Guidelines" (not dated) revealed "...POA (Power of Attorney)/Contact person will be notified...balance in patient trust is close to the limit allowed of $2,000.00..." Interview with the Resident Account Manager on June 18, 2013, at 8:30 a.m., in the Resident Account Manager's office, revealed the resident's account exceeded the $2000.00 limit in January 2013, after the resident received a lump sum check of $18,256.00. Continued interview confirmed no documentation the facility had notified the resident or the resident's representatives of the SSI resource limit when the amount in the resident's account reached $200 less than the SSI resource limit for one person.	{F 159}		
{F 160} SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final	{F 160}		

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{F 160}	Continued From page 3 accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on review of facility trust account ledger and interview, the facility failed to promptly convey personal funds upon the death of two residents (#76 and #69), of one hundred and thirty-one resident accounts reviewed. The findings included: Resident #76 expired on May 10, 2013. Review of a facility trust fund ledger on June 17, 2013, revealed a balance of $2,159.14 in the resident's trust account. Resident #69 expired on May 12, 2013. Review of a facility trust fund ledger on June 17, 2013, revealed a balance of $2,099.01 in the resident's trust account. Interview with the Business Office Manager on June 17, 2013, at 1:20 p.m., in the Business Office Manager's office, confirmed the balance in the trust accounts had not been returned to the residents' estate.	{F 160}	1. On July 18, 2013 the credit balances on resident # 76 and # 69 were refunded to the executor of the estates. 2. On July 15, 2013 the trust fund accounts where residents had been discharged/death were reviewed by the Business Office Manager for credit balances and none were found with a date of greater than 30 days. 3. The patient trust fund representative will receive a daily census log and will log (Attachment 2) and review the date of discharge/death to assure the trust fund account is closed within 30 days of discharge/death. 4. The Business Office Director will monthly audit the discharge/death log (Attachment 3) to assure the account is closed within 30 days of discharge/death. A monthly accounting will be given to the QAPI Committee. Attachments: 2. Discharge/Death Log 3. Discharge/Death Audit Form	07/18/13
{F 166} SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	{F 166}	1. On 6/12/13 a Share Card was completed for Resident # 21 concerning missing money. An investigation was conducted by Social Services Director regarding Resident # 21. On 6/12/13 Resident 21 was reimbursed the amount of money she stated she was missing.	07/18/13

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(F 166)	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to promptly resolve grievances for two residents (#21 and #210) of fifty-six residents reviewed. The findings included: Resident # 21 was admitted to the facility on February 21, 2011, with diagnoses including Congestive Heart Failure, Pleural Effusion, Pulmonary Hypertension, Anemia, and Depression. Review of a Social Service (SS) Progress Note dated August 14, 2012, revealed "...can voice all needs and wants..." Review of a SS Progress Note dated August 31, 2012, revealed "...had money missing...room searched...put on alert...look & (and) report any money..." Review of a (SS) Progress Note dated September 3, 2012, revealed "... no money turned in, nsg (nursing) aware...talked c (with) staff about this..." Review of a SS Progress Note dated October 25, 2012, revealed "...money not found..." Review of a SS Progress Note dated June 12, 2013, revealed "...SW (Social Worker) was made aware of issue r/t (related to) money missing...has been reimbursed..."	(F 166)	On 6/9/13 Resident # 210's husband verbalized to Therapy personnel that his wife's geri-chair was too heavy for him to push. After discussion with Therapy Director, Resident # 210 was fitted with a Broda chair. Resident's husband expressed that this chair was much easier to propel. On 7/12/13 the Administrator, DON, and Social Services Director reviewed and revised the Grievance process policies and forms.(#4) The revised process, policy and forms were approved by the Medical Director on 7/19/13. Nurses, Managers and Social Services staff were provided with in-service education (#5) by the Administrator on the grievance process, policy and forms on 7/18/13. Families and residents are made aware of the grievance process upon admission and forms are kept at the nurses' desks. 2. On July 18, 2013 the Social Services Director reviewed the resident council minutes and found no unresolved grievances. 3. A new log and grievance form (#4) has been developed. The log will be maintained in the Social Services office. The Administrator will monitor the grievances, concerns and complaints investigated to ensure all resident grievances are logged and investigated according to policy. Monitoring will begin on 7/15/13 on a weekly basis with review of 100% of grievances. Results of monitoring will be reported to the QAPI Committee by the Social Services Director. The QAPI Committee will evaluate the frequency of monitoring based on compliance with the policy after 6 months. 4. The Social Services Director will report monitoring of the July outcomes of concerns, complaints, and grievances at the 8/14/13 QAPI Committee meeting and monthly thereafter until monitoring and reporting are changed based on facility compliance. The Administrator will report outcomes to the governing body monthly.	

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{F 166}	Continued From page 5 Interview with the SW on June 12, 2013, at 8:30 a.m., at the Wing 1 Nurses Station, confirmed the facility had failed to resolve the greivance of missing money until brought to the attention of the facility by the surveyor on June 12, 2013, (10 months later). Resident #210 was admitted to the facility on November 21, 2012, with diagnoses including Pneumonia, Neurological Disorder Multiple Infarcts, Dementia, Tracheostomy, Gastrostomy, Encephalopathy, and late effects Viral Encephalopathy. Interview with the resident's spouse on June 10, 2013, at 4:20 p.m., in the Wing 2 dining area, revealed the spouse was unable to push the resident's wheelchair due to the heaviness and unyieldingness of it. Stated "...I've asked for a lighter one and they told me I couldn't get it..." Further interview revealed the spouse would like to push the resident around the facility but is unable to push the wheelchair "...it is too hard to push..." Contined interview revealed spouse had discussed the request with the Activity Aide and the Therapy Director. Interview with the Activities Director and the Activity Aide on June 11, 2013, at 8:45 a.m., in the Activities Office, confirmed the resident's spouse had requested an easier wheelchair to push "a few months ago." Interview with the Therapy Director on June 12, 2013, at 9:20 a.m., in the conference room, revealed the spouse had spoken to him about a wheelchair the spouse could push to take the resident to activities. The Therapy Director stated	{F 166}	Attachments: # 4 Revised Resident Grievance Policy and Procedure, Log and Form # 5 In-Service Log of Attendance	

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(F 166)	Continued From page 6 had attempted a different chair but there was a mechanical problem so could not use that chair. Further interview revealed had "thought about" a "Broda" Chair but "need to get permission for that." Observation on June 18, 2013, at 5:00 p.m., at the Wing 2 nursing station, revealed the resident in a reclining type wheelchair with the spouse attempting to push it. The spouse was having difficulty and a staff member assisted. Interview with the Therapy Director on June 12, 2013, at 9:20 a.m., in the conference room, confirmed the facility failed to resolve the grievance.	(F 166)		
(F 221) SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain an order for a restraint for one resident (#71) of 5 residents reviewed. The finding included: Resident #71 was admitted to the facility on January 17, 2011, with diagnoses including Osteoarthritis, Dementia, Alzheimer's Disease, Depression, and Anxiety.	(F 221)	RESIDENT # 71 1. The DON, Administrator, Medical Director, and Clinical Manager reviewed Physician Orders on resident # 71 on 6/26/13. Resident received clarification order for softbelt while up in w/c due to unsteady gait and decreased cognition on 6/26/13. The order was faxed to Pharmacy, placed on careplan and documented on current MAR. 2. On 7/11/13, the DON, ADON, Staff Development Nurse, and Clinical Managers assessed all residents with restraints to ensure orders are current on MARs and physician orders. The MDS Coordinator reviewed the careplan and MDS assessment for compliance and no update needed. Beginning 7/11/13, a restraint log (P) was completed for all residents who had restraints by DON and/or ADON and	07/15/13

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{F 221}	Continued From page 7 Medical record review of a quarterly Minimum Data Set (MDS) dated April 30, 2013, revealed the resident had severe cognitive impairment, required extensive assistance of one for transfers, two or more falls without injury, and no restraint used. Medical record review of a Care Plan dated January 3, 2012, revealed "...at risk for falls...fall 3/23/13...no injury...soft belt applied..." Medical record review of a Pre-Restraining Assessment dated March 23, 2013, revealed "...Interdisciplinary Team Evaluation...Recommendations: O.T (occupational therapy) eval (evaluation) W/C (wheelchair) positioning..." Medical record review of an Informed Consent dated March 25, 2013, revealed the family had given verbal consent for restraint use. Medical record review of a Positioning/Splinting/ADL (activity of daily living) Screen dated May 30, 2013, revealed "...restraint reduction unsuccessful..." Medical record review of a Physical Restraint Elimination Assessment dated May 31, 2013, revealed "...Cont (continue) with seat belt..." Medical record review of the Physician's Recapitulation Order's dated June 1, 2013, through June 30, 2013, revealed no order for soft belt restraint. Observation on June 10, 2013, at 10:43 a.m., in	{F 221}	Clinical Managers. This log will be maintained by the Clinical Manager and provided to DON at the morning meeting 1 x wk. On 7/15/13, an in-service was conducted regarding Notification of Physician for Orders (Q)including restraints. This was done by DON and/or Staff Development Nurse for nurses. Any nurse not attending will be in-serviced upon return to work by DON/ADON/Staff Development Nurse. 3. Beginning on 7/11/13, DON, Administrator, Medical Director, ADON, Clinical Managers and MDS Coordinators will review all restraints monthly and more often if necessary. The Clinical Managers will present restraint assessments and any changes or issues at this time regarding restraints. Clinical Managers will place all residents with restraints on a restraint montoring log (P) and maintain on their unit. The Clinical Managers will monitor residents daily for appropriate care and documentation beginning 7/11/13 for 4 weeks then weekly for 4 weeks then monthly until substantial compliance has been obtained as reviewed by the QAPI committee. 4. Beginning on 7/15/13, Clinical Managers will report weekly to the DON concerning the monitoring of restraints at the morning meetings. The DON will report the restraint monitoring outcomes to the QAPI committee beginning with the QAPI meeting 7/10/13. The Administrator will report to the governing body concerning these monitoring outcomes on a quarterly basis or more often as necessary.	

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(F 221)	Continued From page 8 the Wing One Dining Room, revealed the resident in a wheelchair with a soft belt restraint in place. Interview on June 11, 2013, at 3:55 a.m., in the Wing One Nurse's Station, with the Wing One Unit Manager, confirmed the facility failed to obtain a physician's order for the soft belt restraint.	(F 221)		
(F 225) SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	(F 225)	1. Resident # 134 sustained fx femur on 11/13/12. DON sent Unusual Event Report to the State of Tennessee on 7/10/13 describing the event and the findings of investigation. No other action was required. 2. Quality Assurance (QA) nurse reviewed incidents of unknown origin for the past 60 days which may be reportable to state and none were noted. 3. QA Nurse will investigate each incident for unknown origin per policy (R). Nurses and Clinical Managers will investigate immediately upon occurrence or discovery to determine if the incident is an unknown origin. An Unusual Event Report will be completed and sent to the State of Tennessee when incident occurs which meets the regulation criteria. Incidents will be reviewed and discussed upon occurrence at the morning meting with DON, ADON, Clinical Mangers, Rehab and Administrator. At the monthly review of incidents with the Medical Director it will be discussed as an unknown incident and so noted on the incident report.	07/15/13

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(F 225)	Continued From page 9 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, review of facility policy, and interview, the facility failed to submit a written report of an injury of unknown origin to the State Department of Health for one resident (#134) of eighteen residents reviewed for accidents. The findings included: Review of facility documentation revealed on November 13, 2012, staff noted edema to Resident #134's right knee. The resident was transferred to the Emergency Room and found to have a distal femur fracture. Continued review of facility documentation dated November 16, 2012, revealed the Unusual Event Report had been completed but the facility did not send the report to the State of Tennessee. Review of facility policy, Reporting of Incidents to State, no date, revealed "...The facility will report all required incidents within 7 business days..." Interview with the Director of Nursing (DON) on June 13, 2013, at 8:05 a.m., in the DON Office,	(F 225)	4. Beginning July 10, 2013, the DON will report any incident reported to the State of Tennessee due to unknown origin to the QAPI committee. The Administrator will report to the governing body these monitoring outcomes on a quarterly basis or more often as necessary.	

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{F 225}	Continued From page 10 confirmed the facility failed to submit a written report of an injury of unknown origin resulting in a fractured femur to the State of Tennessee.	{F 225}		
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the dignity and respect for three residents (#9, #209, and #58) of five residents observed dining, in one of six dining rooms (the Sunshine Dining Room) and failed to ask permission before placing clothing protectors on twenty-four residents, in one of six dining rooms (wing 1 dining room) of six dining rooms observed. The findings included: Observation on June 10, 2013, at 12:12 p.m., in the Sunshine Dining Room, revealed a table seated with five residents. Continued observation revealed resident #111 and resident #177 had their lunch trays and were eating. Further observation revealed residents #9, #209, and #58 were not eating and were looking around the dining room. Continued observation at 12:16 p.m. (4 minutes after residents #111 and #177 began eating), revealed resident #9 received a lunch tray and	{F 241}	Resident # 9, #209, #58 1. The Dietary Department was notified on 6/10/13 of residents # 9, #209, and #58 attending the Sunshine Room during meals. Trays will be placed on the cart to be delivered to the Sunshine Room effective 6/10/13. In-servicing regarding dignity issues, delivery of trays, and placing clothing protectors (S) began on 7/12/13 for nursing and staff assisting with meal delivery by DON/ADON/ Staff Development Nurse and is ongoing. 2. All residents were assessed for their preference pertaining to use of a clothing protector by the Clinical Manager on 7/12/13. A list of residents who prefer to have clothing protectors will be available for staff in the dining areas effective 7/12/13. In addition to the list each resident will be asked prior to having clothing protector placed. Dietary Department will continue to be notified verbally or in writing when a resident's location for meals change by the nursing staff or clinical manager immediately prior to delivery of trays.	07/15/13

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{F 241}	Continued From page 11 began eating. Continued observation at 12:22 p.m. (10 minutes after residents #111 and #177 began eating), revealed residents #209 and #58 received their lunch trays and staff members sat down beside them to assist with feeding. Further observation revealed resident #177 had finished eating when residents #209 and #58 received their trays. Interview with Restorative Aide #1 on June 10, 2013, at 12:31 p.m., in the Sunshine Dining Room, revealed residents #9, #209, and #58 lunch trays were delivered to the wing where the residents' rooms were located and someone had to go retrieve the trays from those wings and bring to the Sunshine Dining Room. Interview with Unit Manager #3 on June 10, 2013, at 12:40 p.m., in the Sunshine Dining Room, revealed the Sunshine Room was for residents who need one-on-one supervision and was the dining room for residents with behaviors. Further interview confirmed the three residents did not get their trays with the other two residents and "I don't know why." Observation of the Wing I dining room, on June 10, 2013, from 11:45 a.m., until 12:10 p.m., revealed the Care Assistant Technician (CAT) #1 placed clothing protectors on twenty-four residents without asking permission from each resident before placing the clothing protectors. Interview with CAT #1 on June 10, 2013, at 12:33 p.m., at the Wing 1 Nurses' station, confirmed none of the twenty-four residents had been asked permission before placing the clothing protectors.	{F 241}	3. DON/ADON or Clinical Managers will make a Dining Observation using the Dining Observation tool (T) beginning 7/15/13 on a weekly basis for 4 weeks then monthly. Results of the dining observations will be reported to the QAPI committee at each meeting. 4. Beginning July 2013, the Clinical Managers will report weekly to the DON concerning the monitoring of dining observations at the morning meetings. The DON will report the dining observation monitoring outcomes to the QAPI committee beginning with the August QAPI Meeting. The Administrator will report to the governing body concerning these monitoring outcomes on a quarterly basis or more often as necessary.	

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{F 272} SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	(F 272)	Resident # 71 1. The DON, Administrator, and MDS Coordinator reviewed MDS assessment dated 04/30/13 for resident # 71 on 7/9/13. MDS modification and submission (U) done on 7/9/13 reflecting use of trunk restraint when up in w/c . Modification was made to the MDS Assessment with an ARD Date of 4/30/13 for Resident # 71. The correction was made to Section P, Item A, identifying a trunk restraint for the resident. The modification was transmitted on 7/9/13. 2. The DON, ADON, Clinical Managers and MDS Coordinator reviewed all residents with restraints to ensure MDS assessments were correctly coded and up to date on 7/11/2013. There were no corrections identified in the review. 3. Beginning 7/15/13, the MDS Coordinators will review restraints marked on MDS assessments and careplans for accuracy in the weekly careplan conference with the Clinical Managers. Beginning August, the DON or ADON will review four careplans per month which include restraints for six months or until substantial compliance is met as approved by the QAPI committee. DON will report results of monitoring at QAPI meeting. 4. Beginning Aug 2013, the DON will report the MDS monitoring outcomes to the quarterly QAPI committee 8/14/13. The Administrator will report to the governing body concerning these monitoring outcomes on a quarterly basis or more often as needed.	07/15/13

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(F 272)	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to complete an accurate comprehensive assessment for one resident (#71) of fifty-six residents reviewed. The findings included: Resident #71 was admitted to the facility on January 17, 2011, with diagnoses including Osteoarthritis, Dementia, Alzheimer's Disease, Depression, and Anxiety. Medical record review of a Care Plan dated January 3, 2012, revealed "...at risk for falls...fall 3/23/13...no injury...soft belt applied..." Medical record review of a Pre-Restraining Assessment dated March 23, 2013, revealed "...Interdisciplinary Team Evaluation...Recommendations: O.T. (occupational therapy) eval (evaluation) W/C (wheelchair) positioning..." Medical record review of a quarterly Minimum Data Set (MDS) dated April 30, 2013, revealed the resident had severe cognitive impairment, required extensive assistance of one for transfers, two or more falls without injury, and no restraint used. Medical record review of a Physical Restraint Elimination Assessment dated May 31, 2013, revealed "...Cont (continue) with seat belt..."	(F 272)		

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{F 272}	Continued From page 14 Observation on June 10, 2013, at 10:43 a.m., in the Wing One Dining Room, revealed the resident in a wheelchair with a soft belt restraint used. Interview on June 11, 2013, at 3:55 p.m., in the Wing One Nurse's Station, with the Director of Nursing, confirmed the comprehensive assessment was not accurate.	{F 272}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documentation, and interview, the facility failed to	{F 280}	Resident # 111, #141 1. On 7/9/13, the DON, Administrator, ADON, Clinical Managers and MDS Coordinators reviewed and revised the careplan for resident #111 to remove "1:1 Supervision" and add "attends sunshine room for direct supervision" and Resident # 141 careplan to reflect "re-educate to use call light when in need of assistance". 2. On 6/25/13, DON, ADON, Clinical Managers and MDS Coordinators reviewed falls for the last 45 days to ensure that the fall interventions were correct on the careplans. Corrections were applied to three careplans and a list of residents whose careplans were changed were reported to the DON on 6/25/13. A memo communicating the changes to the careplans were sent to the nursing staff on 6/25/13 and signed by staff as inserviced and put in in-service book to be reviewed by Clinical Managers. 3. The DON, Administrator, ADON, Clinical Managers, and MDS Coordinators will review all falls in the morning meeting. The MDS Coordinators and Clinical Managers will review the careplan at this time to ensure that the fall interventions are in place. The ADON and MDS Coordinators will review occurrences and ensure interventions are on the careplans and assess resident for compliance.	07/15/13

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{F 280}	Continued From page 15 revise the care plan for two residents (#111 and #141) of fifty-six residents reviewed. The findings included: Resident #111 was admitted to the facility on August 24, 2010, with diagnoses including Atrivent Block First Degree, Cardiac Dysrhythmias, Cardiomegly, Congestive Heart Failure, and Sinoatrial Node Dysfunction. Medical record review of the Care Plan for the Problem Category of Falls revealed an intervention dated May 19, 2011, "...Restorative Nursing for Ambulation R/T (related to) unsteady gait...risk factor: accidents..." The Care Plan had been updated for review ten times and had a new target date of September 10, 2013. Continued review of the Care Plan revealed on December 21, 2011, "...Fall: 12/21/11 no injury 1:1 (one on one) supervision..." No changes to the one on one intervention had been made since December 21, 2011. Review of facility documentation revealed on June 4, 2013, at 4:30 a.m., "...activity referral for early awakening prior to sunshine room attendance..." Medical record review of the care plan revealed no documentation of the intervention for the sunshine room. Interview with the Director of Nursing (DON) on June 17, 2013, at 2:05 p.m. in the DON office confirmed the care plan had not been revised to reflect the intervention of June 4, 2013. Continued interview with the DON confirmed the	{F 280}	Beginning August 2013 the DON or ADON will review four care plans per month which include falls for six months or until substantial compliance is met as approved by the QAPI committee. DON will report results of monitoring at the QAPI meeting. 4. Beginning Aug 2013, the DON will report careplan monitoring outcomes at the scheduled 8/14/13 QAPI committee meeting. The Administrator will report to the governing body concerning these monitoring outcomes on a quarterly basis or more often as necessary.	

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{F 280}	Continued From page 16 resident intervention of 1:1 from December 21, 2011, was no longer in place and the care plan for 1:1 had not been revised. Resident #141 was admitted to the facility on August 19, 2008, with admitting diagnoses of Urinary Tract Infection, General Osteoarthritis, Renal & Ureteral Disorder, Spasm of Muscle, Generalized Pain, Bone/Skin Neoplasm, and Osteoporosis. Review of the facility's documentation of falls that occured on April 16, 2013, and May 18, 2013, revealed an intervention of "re-educate to use call light when in need of assistance". Medical record review of the Care Plan for falls revealed the new intervention for fall prevention for the falls on April 16 ,2013, and May 18, 2013, had not been added to the Care Plan. Interview with the DON on June 13, 2013, at 9:45 a.m., in the conference room, confirmed the resident's Care Plan had not been revised to reflect the fall intervention ordered.	{F 280}		
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of the facility's contract with the dialysis provider,medical record review and interview, the facility failed to ensure well-being,	{F 281}	Resident # 230 1. A clarification order for dialysis was obtained on 6/13/13. A dialysis communication form was constructed for use on 6/13/13. Dialysis clinic received communication from BHRC nurse and returned documentation/communication with resident appointment info. 2. There are no other residents receiving dialysis at the dialysis center at this time. All new communication forms (V) are in place. Staff in-servicing regarding	07/08/13

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{F 281}	Continued From page 17 for one resident (#230) of one resident receiving dialysis, of fifty-six residents reviewed. The findings included: Resident #230 was admitted to the facility on June 3, 2013, with diagnoses including Sepsis, Pneumonia, End Stage Renal Disease, Diabetes Mellitus II, Pressure Ulcer, and Mental Disorder. Medical record review revealed the resident routinely received dailysis from the contracted dialysis provider and revealed no facility to facility communication. Review of the facility contract with the dialysis facility revealed "...responsibilities of BHRC (Bradley Health Care & Rehab)...BHRC staff will make an assessment of each patient's physical condition and determine whether the patient is stable enough to be dialyzed...this assessment will be communicated to the facility's nurse manager or...designee. This assessment and communication will occur prior to each and every transfer of a patient to...for hemodialysis...regardless of the number of times any particular patient may be transferred and dialyzed...Responsibilities of (the dialysis clinic)...shall provide relevant information regarding each patient's dialysis treatment...shall provide instruction to certain designated employees of BHRC about the proper care and treatment of a dialysis patient's vascular access...and about the care and treatment and monitoring of a patient with chronic renal failure...information which may be utilized in the development and maintenance of BHRC's patient care plans..."	{F 281}	care of a dialysis resident policy (V) began on 7/8/13 and is ongoing as needed per Clin Mgr. 3. In-servicing regarding care of resident and communication tools (V) will be ongoing to ensure policy and contract is followed. Clinical Managers will review communication tools and dialysis clinic notes after each appointment. DON and/or ADON will be notified if any discrepancies arise. 4. Clinical Managers will review for compliance and any reports/trends of concern will addressed to the QAPI committee by DON beginning with the scheduled 8/14/13 QAPI meeting. The Administrator will report to the governing body on a quarterly basis or more often as necessary.	

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{F 281}	Continued From page 18 Interview with Unit Manager #1, on June 13, 2013, at 9:50 a.m., in the Wing 1 nursing station, confirmed there was no order for the dialysis. Continued interview with the Unit Manager confirmed no staff education regarding dialysis and shunt site care had been completed for the Nurses or the Certified Nursing Assistants. Further interview revealed the facility received a faxed copy of the Outpatient Dialysis Flowsheet from the dialysis facility if they "call and ask for it." Further interview confirmed the only communication between the facility and the dialysis facility was a phone call "if needed". The information was not sent back to the facility immediately post dialysis and no regular communication was provided. Continued interview confirmed there was no facility to facility communication including documentation of assessment by the facility prior to sending the resident to dialysis and no documentation from the dialysis center communicating the care and condition of the resident during and returning from dialysis. Further interview with the Unit Manager confirmed the facility contract with the dialysis center had not been followed.	{F 281}		
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	{F 323}	1. # 134 Treatment plan and falls interventions were reviewed by DON, ADON, and MDS Coordinator on 6/20/13, noting clarifications to interventions on 6/19/13 being fall mats next to bed (not PRN) and on 6/24/13 clarification of assist up for meals and offer assistance to Dining Room (resident refuses at times), resident fed by staff in room as needed. Fall Interventions for this resident are: Low bed in low position and wheels	07/15/13

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{F 323}	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility fall investigation documentation, interview, review of manufacturer's recommendations, observations, review of facility restraint committee meeting minutes and review of the facility policy for Sunshine Room Guidelines, the facility failed to provide supervision to prevent accidents for ten residents (#134, #37, #58, #71, #95, #111, #52, #193, #2, #18) of fifty-six residents reviewed and failed to a apply soft belt restraint according to manufacturer's instructions for one resident (#13) of five soft belt restraints reviewed. The facility's failure placed four residents (#134, #37, #58, #71) in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) of eighteen residents reviewed for falls. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls in Immediate Jeopardy. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 9, 2013, revealed the corrective actions implemented removed the Immediate Jeopardy on June 29, 2013. Non- compliance for F-323 continues at an "E" level citation.	{F 323}	locked, fall mats beside bed, soft belt restraint in w/c, up for meals as tolerated, bed alarm. Resident care plan was reviewed on 6/19/13 by MDS Coordinator and DON assessed resident care plan and spoke with resident on 6/20/13. Resident was in w/c with no distress noted. Medical Director reviewed treatment plan, including falls interventions and reaffirmed plan of care on 6/25/13. Direct care staff was in-serviced on intervention changes on 6/24/13 by Clinical Manager and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ ADON, Staff Development Nurse for compliance – random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. ADON did a room check on equipment and environment on 6/19/13 ensuring proper devices were in place and operational (low bed, floor mat, bed alarm). #37 Treatment plan and falls interventions were reviewed by DON,ADON, and MDS Coordinator on 6/20/13, with changes to care plan being anti-tippers to w/c on 6/24/13. Fall interventions for this resident are: bed against wall, floor mat, anti-tippers on w/c, soft belt in w/c, and chair alarm in	

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{F 323}	Continued From page 20 Validation of the Credible Allegation of Complaince was accomplished through medical record review,review of facility communication books, observation and interview with front line staff and administrative staff. The facility provided evidence of new policies and procedures related to accidents and supervision, chair and bed alarms, the facility quality improvement program and evidence the Medical Director and Administrator had reviewed and approved all policies and procedures. Inservice and training records including sign-in sheets for all nursing and non-nursing staff related to the new policies and procedures were provided. Interviews with nursing staff revealed nurses and certified nursing assistants were following the new policy and procedure realted to accidents and supervision, alarms and facility quality improvement. Observations revealed assistive devices were properly applied and functioning, certified nursing assistants were conducting alarm checks, and facility communication books were being utilized. The facility will remain out of compliance at a Scope and Severity level "E"- no actual harm with potential for more than minimal harm that is not immediate Jeopardy until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/ Performance Improvement Committee.	{F 323}	room. DON assessed resident and care plan on 6/24/13. Changes/updates made to care plan, resident in w/c with soft belt applied. Medical Director reviewed treatment plan, including falls interventions and reaffirmed plan of care on 6/25/13. Direct care staff was in-serviced by Clinical Manager on 6/24/13 and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ ADON, Staff Development Nurse for compliance – random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. ADON did a room check on equipment and environment on 6/19/13 ensuring proper devices were in place and operational (floor mat, anti-tippers on w/c, soft belt and chair alarm).	
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	{F 329}		

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{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	{F 329}	ADON did a room check on equipment and environment on 6/20/13 ensuring proper devices were in place and operational (floor mat, bed and seat belt alarms).	

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{F 323}	Continued From page 20 Validation of the Credible Allegation of Complaince was accomplished through medical record review,review of facility communication books, observation and interview with front line staff and administrative staff. The facility provided evidence of new policies and procedures related to accidents and supervision, chair and bed alarms, the facility quality improvement program and evidence the Medical Director and Administrator had reviewed and approved all policies and procedures. Inservice and training records including sign-in sheets for all nursing and non-nursing staff related to the new policies and procedures were provided. Interviews with nursing staff revealed nurses and certified nursing assistants were following the new policy and procedure realted to accidents and supervision, alarms and facility quality improvement. Observations revealed assistive devices were properly applied and functioning, certified nursing assistants were conducting alarm checks, and facility communication books were being utilized. The facility will remain out of compliance at a Scope and Severity level "E"- no actual harm with potential for more than minimal harm that is not immediate Jeopardy until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/ Performance Improvement Committee.	{F 323}	continues to in-service CNAs, LPNs, RNs and Rehab staff on proper placement of restraint. Medical Director and Administrator approved revised fall prevention policies (A) and procedures including Falls Incident Packet (B), Alarm Policy (C), Tracking log (E) and checks (D) on 6/25/13. On 6/25/13, DON met with Clinical Managers, ADON, Staff Development Nurse, and MDS nurses to review and revise above policies and forms (A,B,C,D,E) and develop process for implementation and monitoring of these. Mandatory in-servicing on developed forms B,C,D and E to CNAs, LPNs, and RNs on 6/25/13 by DON and/or Clinical Managers and Staff Development Nurse. No CNA, LPN, or RN will be allowed to work until in-serviced on policies and procedures B, C, D, and E. In-services on policies B,C, D, and E will be conducted on an ongoing basis with follow-up tests (F) and then follow-up tests (F) every 3 months. In-services will be conducted by DON, ADON, Clinical Managers and/or Staff Development Nurse.	
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	{F 329}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 323}	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility fall investigation documentation, interview, review of manufacturer's recommendations, observations, review of facility restraint committee meeting minutes and review of the facility policy for Sunshine Room Guidelines, the facility failed to provide supervision to prevent accidents for ten residents (#134, #37, #58, #71, #95, #111, #52, #133, #2, #18) of fifty-six residents reviewed and failed to a apply soft belt restraint according to manufacturer's instructions for one resident (#13) of five soft belt restraints reviewed. The facility's failure placed four residents (#134, #37, #58, #71) in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) of eighteen residents reviewed for falls. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls in Immediate Jeopardy. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 9, 2013, revealed the corrective actions implemented removed the Immediate Jeopardy on June 29, 2013. Non-compliance for F-323 continues at an "E" level citation.	{F 323}	2. On 6/20/13, DON/ADON, Clinical Managers and Staff Development Nurse assessed all residents with falls to ensure appropriate interventions are in place. Residents at risk: 25 residents were identified at risk on 6/25/13 having falls with the past 45 days. Three resident interventions were updated on nursing careplans after Clinical Manager/DON/ADON/Staff Development Nurse reviewed. Updates charted by Clinical Manager and/or ADON/Staff Development Nurse. Direct care staff in-serviced by Clinical Manager and then in-service information placed in the in-service communication book and interventions added to nursing and CNA Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ADON, Staff Development Nurse for compliance – random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/ written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. The other 22 resident interventions already in place are still current and effective. All devices were tested for functionality per ADON, completed 6/23/13 and ongoing per policy (D), chair and bed alarm policy were put into place (C), assessment of assistive device (E), and alarm check forms (D). New interventions will be determined per resident need and nurses have been given a falls prevention – potential interventions (M) for assistance to nurses when determining care for residents when need is evident by occurrence.	

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{F 323}	Continued From page 20 Validation of the Credible Allegation of Complaince was accomplished through medical record review,review of facility communication books, observation and interview with front line staff and administrative staff. The facility provided evidence of new policies and procedures related to accidents and supervision, chair and bed alarms, the facility quality improvement program and evidence the Medical Director and Administrator had reviewed and approved all policies and procedures. Inservice and training records including sign-in sheets for all nursing and non-nursing staff related to the new policies and procedures were provided. Interviews with nursing staff revealed nurses and certified nursing assistants were following the new policy and procedure realted to accidents and supervision, alarms and facility quality improvement. Observations revealed assistive devices were properly applied and funotioning. certified nursing assistants were conducting alarm checks, and facility communication books were being utilized. The facility will remain out of compliance at a Scope and Severity level "E"- no actual harm with potential for more than minimal harm that is not immediate Jeopardy until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/ Performance Improvement Committee.	{F 323}	On 6/25/13, DON/Clinical Mangers placed the falls incident packet (B) on each Nursing station for use after staff in-servicing began on 6/25/13. 3. Beginning 6/25/13 the charge nurse on each nursing unit will implement new interventions to be determined per resident need as evident by an occurrence. On 6/25/13 the Staff Development Nurse placed a falls prevention - potential interventions (M) for assistance to nurses when determining care for residents when a fall occurrence happens. Nurses will update nursing careplans and CNA careplans if occurrence occurs. On 6/25/13, the DON reviewed all incidents which includes falls within 72 hours for appropriate interventions, care planned with new interventions and investigated accurately. 4. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily until July 15, 2013, then weekly. DON and/ or ADON, Staff Development Nurse will review in-service sheets two times a week until August 26, 2013 and then weekly for compliance. CNA careplans and nursing careplans regarding fall occurrences will be reviewed by Clinical Manager and MDS Coordinator with each occurrence. The outcomes of the monitoring tools put in place (Falls Incident Packet (B), falls intervention roster (K), alarm checks (D) will be reviewed by DON and/or ADON, Staff Development Nurse every two weeks beginning 7/15/13. Beginning at the 7/10/13 QAPI meeting, outcomes of the falls, careplan, alarms and intervention roster monitoring tools were submitted by the DON and the Administrator will report outcomes to the governing body at his meetings.	
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including			

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{F 329}	Continued From page 21 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure unnecessary medications were not administered to one resident (#154) of ten residents reviewed. The findings included: Resident #154 was admitted to the facility on February 14, 2013, with diagnoses including Hyperlipidemia, Hypertension, Heart Disease, Vitamin D Deficiency, Anemia, Dysphasia, and Obstructive Sleep Apnea.	{F 329}	Resident # 154 1. Upon being notified on 5/20/13 of the resident receiving Ampicillin, the charge nurse reported to Nurse Practitioner (NP) and the antibiotic was changed to Ceftin – no allergic reactions were noted. On 7/12/13, the DON placed a reminder note on the Emergency Drug Box to check for any allergies prior to administering any drug taken from the Emergency Drug Box. Licensed nurses were in-serviced (W) regarding checking for allergies prior to writing any order given for medication(s) and checking sticker on front of chart beginning 7/12/13 by the DON/ADON/Staff Development. Nursing staff not attending will be in-serviced upon return to work by the DON/ADON/Staff Development Nurse. 2. On 7/12/13 all resident's medical records were rechecked by the DON/ADON/Clinical Managers for correct allergies posted on front of chart and medications ordered for allergies. The Pharmacy Services also checked their database for resident profile medications for possible allergies. This was completed on 7/15/13. All resident medical records were accurate. 3. Pharmacy Services will notify facility nurse before filling order if a medicine ordered is contraindicated. Beginning 7/15/13 the DON/ADON/Pharmacy Consultant will monitor monthly for any incident or near misses of administering medication that residents are allergic to. The ADON/Clinical Managers will review the infection control sheet daily which is to be completed upon order of antibiotic, antiviral medication to include allergies listed.	07/15/13

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{F 329}	Continued From page 22 Medical record review revealed the resident was allergic to Penicillin. Medical record review of a Laboratory Report dated May 18, 2013, revealed the resident had a Urinary Tract Infection and the organism was susceptible to Ampicillin (antibiotic). Medical record review of a Telephone Order dated May 18, 2013, revealed "...start Ampicillin (a type of penicillin) 500 mg (milligram) TID (three times a day) x (times) 7 days." Medical record review of a Medication Administration Record (MAR) dated May 1, 2013, through May 31, 2013, revealed the resident received five doses of the Ampicillin 500 mg on May 18, 2013, at 3:00 p.m. and 9:00 p.m., May 19, 2013, at 9:00 a.m., 3:00 p.m., and 9:00 p.m. Medical record review revealed no documentation of adverse drug reactions. Interview with the Assistant Director of Nursing (ADON) on June 18, 2013, at 9:30 a.m., in the ADON Office, confirmed the resident had an allergy to Penicillin and received five doses of the Ampicillin on May 18 and 19, 2013.	{F 329}	A modified form is in use until new form is received. (Tentative date 7/26/13) Results of the monitoring will be reported weekly at the morning meeting. 4. Beginning August 2013, the DON will report any medication errors dealing with administration of medications when resident has an allergy and the monthly monitoring outcomes to the scheduled August QAPI committee meeting. The Administrator will report to the governing body concerning these monitoring outcomes on a quarterly basis or more often as necessary.	
{F 371} SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	{F 371}	1. On June 10, 2013 the Dietary manager and staff cleaned the white dried debris underneath the mixer head and black debris inside the ice machine. On June 12 the Dietary Manager conducted a one on one in-service with Dietary Aide #2 and #3 concerning washing hands and what to do when dropping items on the floor.	7/18/13

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{F 371}	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to provide sanitary storage of equipment in the kitchen and failed to maintain food temperatures. The findings included: Observation with the Certified Dietary Manager (CDM) on June 10, 2013, at 10:15 a.m., in the kitchen, revealed the mixer had a white dried debris underneath the mixer head and the ice machine had a black debris inside the ice machine. Interview with the CDM confirmed the mixer and the ice machine were dirty. Observation on June 10, 2013, at 10:35 a.m., in the kitchen, revealed Dietary Aide (DA) #2 dropped a water pitcher on the floor, picked it up, placed it back on the shelf for use. Continued observation revealed a second DA retrieved the water pitcher and started to use it. The CDM stopped the DA from using the water pitcher after the Surveyor told the CDM about the incident. Interview with DA #2 confirmed the water pitcher was dropped on the floor and placed back on the shelf for use. Observation on June 10, 2013, at 11:50 a.m., in the kitchen, revealed DA #1 took the trash to the dumpster and returned to the kitchen, applied gloves without washing the hands, and started putting clean dishes away. Interview with DA #1	{F 371}	2. On 6/12/13, the Administrator met with the Dietary Manager to review the deficiencies and regulatory requirements. The following actions were developed to ensure appropriate cleaning of equipment, infection control practices and food temperatures: On 7/2/13 (#6) the Dietary Manager provided special training to the Dietary staff on procedures for daily cleaning at end of day, chemicals to use and techniques, dropping items in floor, and maintaining food temperatures at or above 140 degrees Fahrenheit for hot food items and at or below 41 degrees Fahrenheit for cold items. Policy (#7) reviewed and revised: Kitchen Sanitation, Infection control, and Food Temperatures logs, revised the weekly equipment cleaning schedule. On 7/2/13 (#6) the Dietary Manager conducted mandatory in-services with Dietary staff on new guidelines of the weekly equipment cleaning schedule (#8) and standard precautions. A second in-service is scheduled for July 18, 2013 (#9) to be conducted by a GBS representative on standard precautions. No employee will be able to return to work until they have been in-serviced on the above policies by the Dietary Manager. The Dietary Manager developed and approved by the Administrator new food temperature logs for temperatures to be recorded before, during, and after tray line on 7/2/13. (#10) The Dietary staff was in-serviced	

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{F 371}	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to provide sanitary storage of equipment in the kitchen and failed to maintain food temperatures. The findings included: Observation with the Certified Dietary Manager (CDM) on June 10, 2013, at 10:15 a.m., in the kitchen, revealed the mixer had a white dried debris underneath the mixer head and the ice machine had a black debris inside the ice machine. Interview with the CDM confirmed the mixer and the ice machine were dirty. Observation on June 10, 2013, at 10:35 a.m., in the kitchen, revealed Dietary Aide (DA) #2 dropped a water pitcher on the floor, picked it up, placed it back on the shelf for use. Continued observation revealed a second DA retrieved the water pitcher and started to use it. The CDM stopped the DA from using the water pitcher after the Surveyor told the CDM about the incident. Interview with DA #2 confirmed the water pitcher was dropped on the floor and placed back on the shelf for use. Observation on June 10, 2013, at 11:50 a.m., in the kitchen, revealed DA #1 took the trash to the dumpster and returned to the kitchen, applied gloves without washing the hands, and started putting clean dishes away. Interview with DA #1	{F 371}	by the Dietary Manager on July 2, 2013 to stop the line in the event that the potentially hazardous food is not at a proper temperature. Potentially hazardous food is to be brought to proper temperature before resuming the tray line. 3. To ensure the deficient practice does not reoccur, beginning 7/15/13 the Administrator will begin checking Dietary Services daily for three weeks then weekly until substantial compliance has been obtained with the cleaning policies. The Dietary Manager will initial the cleaning schedule daily upon observance of the cleanliness of the equipment and compliance of the cleaning schedule. The dietary manager, Asst Mgr or cook will weekly observe food temperatures being recorded and review temperature forms twice weekly. Any issues identified will be evaluated, investigated and an action plan put into place immediately and reported to the Administrator. 4. The dietary manager, Asst Mgr or cook will monitor the equipment cleaning schedule weekly, conduct weekly standard precautions audits, and review food temperature logs weekly to ensure compliance then report outcomes to the Administrator monthly and at every QAPI committee meeting beginning with the 8/14/13 QAPI meeting which will review July outcomes. The Administrator will report all monitoring outcomes at the next Governing Body Meeting.	

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{F 371}	Continued From page 24 confirmed the hands were not washed before handling clean dishes. Observation with the CDM on June 10, 2013, from 11:50 a.m. until 12:15 p.m., revealed serving line 1 food temperatures were: ground meat balls 132 degrees; white gravy 118 degrees; serving line 2 food temperatures were: ground chicken 130 degrees; meat balls 130 degrees; puree spaghetti 116 degrees; and white gravy 130 degrees. Review of facility policy, Food Temperatures, (not dated) revealed "...will serve food in a safe temperature range...hot foods must be 140 degrees and above..." Interview with the CDM at the time of the observation confirmed the food temperatures were not the correct temperature and seventy-five percent of the residents had been served.	{F 371}	Attachments: # 6 Inservice Record of Attendance 7/2/13, Equipment, Handwashing, and Temperatures # 7 Policy and Procedure Equipment, Infection Control, Hot Foods # 8 Weekly Cleaning Schedule # 9 GPS Rep In-Service #10 Food Temperature Logs	
{F 425} SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	{F 425}	Resident # 134, #178 1. The DON, Pharmacy Consultant, ADON, and Clinical Manager reviewed MARS on 7/11/13 for resident # 134 and resident # 178 for the month of June 1-30, 2013. All meds were administered in a timely manner as ordered. Licensed Nurses were in-serviced (Q) regarding timely administration of medication when new order is written by physician/Nurse Practitioner beginning 7/12/13 by the DON/ADON/Staff Development. Nursing staff not attending will be in-serviced upon return to work by the DON/ADON/Staff Development Nurse.	07/15/13

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(F 425)	Continued From page 25 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to administer medications timely for two residents (#134, #178) of ten residents reviewed. The findings included: Resident #134 was admitted to the facility on June 17, 2009, with diagnoses including Anxiety, Depressive Psychosis, and readmitted August 13, 2013, with diagnoses including right femur fracture. Medical record review of a Nurse's Note dated July 9, 2013, at 4:00 p.m., revealed "...Urine C&S (culture and sensitivity) called to Dr. (doctor)...T.O. (telephone order) Ampicillin (antibiotic) 500 mg (milligram) QID (four times per day) x (times) 5 days...placed on MAR (medication administration record), faxed to pharmacy..." Medical record review of the Medication Administration Record (MAR) dated May 1, 2013 through May 31, 2013, revealed Ampicillin 500 mg first dose given at 12 midnight on May 9, 2013.	(F 426)	2. Beginning 7/12/13, the Clinical Mangers audited all physician orders written for the month of July for medication administered timely using a "Medication Monitoring Log" (X). There were no medications administered untimely. 3. As of 7/1/13, the 11p-7a nurse on each wing will audit charts nightly for any new orders to ensure orders are correctly checked and new medications are administered within 4 hours of order or physician notified when this time frame cannot be met. Clinical Manager will notify DON as appropriate of any pertinent findings in the morning meeting. Beginning the week of 7/15/13, the Pharmacy consultant will audit five charts on each wing per week for one month to ensure that medications are administered timely. A list of available medications in the emergency/narcotic box on Wing 2 and Central Supply will be provided to all nurses by 7/15/13 and placed in appropriate notebooks. (Y) 4. Beginning Aug 2013, the DON will report timely administering medication monitoring outcomes at the scheduled 8/14/13 QAPI committee meeting. The Administrator will report to the governing body concerning these monitoring outcomes on a quarterly basis or more often as necessary. Attachments: Timely Medication Administration Log (X) Nursing In-service (Y) Medication List for Emergency Box and Central Supply (Y)	

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(F 425)	Continued From page 26 Interview with the Director of Nursing on June 13, 2013, at 2:35 p.m., in the conference room, confirmed the facility had failed to administer the antibiotic for a Urinary Tract Infection timely and the Ampicillin had been available for immediate administration in the pharmacy back up box. Resident #178 was admitted to the facility on August 11, 2011, with diagnoses including Deep Vein Thrombosis, Scoliosis, Glaucoma, and Chronic Pain. Medical record review of a Provider Note dated May 22, 2013, revealed "...Nsg (nursing) concerned re: (regarding) pt (patient) c/o (complaint of) ears feeling stopped up and decreased hearing..." Medical record review of a Physician's Order dated May 22, 2013, revealed "...Debrox (ear wax drops) 5 gtts (drops) R (right) ear BID (twice daily) x (times) 4 days..." Medical record review of a Nurse's Note dated May 22, 2013, at 1:00 p.m., revealed "...N.O (new order)...Debrox 5 gtts R ear BID x 4 days..." Medical record review of the MAR dated May 1, 2013 through May 31, 2013, revealed the first dose of Debrox ear gtts was given on May 23, 2013, at 9:00 p.m. Interview with the Director of Nursing on June 18, 2013, confirmed the facility had failed to administer the ear drops until thirty-two hours after the Physician had ordered the ear drops and the ear drops were immediately available in the pharmacy back up box.	(F 425)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445141	A. BUILDING _____ B. WING _____	R 07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADLEY HEALTH CARE & REHAB	2910 PEERLESS RD CLEVELAND, TN 37312

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{F 441} SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	{F 441}	1. All shower rooms were scrubbed on 6/11/13 by Environmental Services to remove debris noted on survey. On 6/11/13 tubing and disposable bubble humidifiers for residents # 106 and #203 were changed by Clinical managers and dated. Licensed nurses and CNAs were in-serviced regarding hand hygiene, checking and changing 02 tubing and humidifiers, and reporting compromised showers to Environmental Services Director (Z) beginning 7/15/13 by the DON/ADON/Staff Development. Nursing staff will be in-serviced upon return to work by the DON/ADON/Staff Development Nurse. A post-test will conducted by the Staff Development Nurse and/or DON/ ADON. 2. All shower rooms were inspected by the Administrator and Environmental Services Supervisor on 6/11/13 and 6/12/13 for compliance and no concerns were noted. 3. Shower rooms will be cleaned daily and monitored weekly by Environmental Services Director for 4 weeks or until substantial compliance has been met. Beginning 7/15/13 the Clinical Managers will monitor O2 concentrators for tubing and humidifiers are checked, changed, and dated weekly for 4 weeks and report any findings to the DON. Shower rooms will be monitored weekly by Environmental Services Director and/or lead housekeeper to ensure compliance of infection control prevention. Results of the monitoring will be reported to the DON weekly and to the scheduled 8/14/13 QAPI committee meeting. On 7/15/13, the Clinical Managers will observe hand hygiene in dining rooms and resident care areas using a monitoring tool (Z) for observation in dining	07/15/13

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{F 441}	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to maintain a clean and sanitary environment in six (Wing 1, Wing 3, Wing 4) of eight shower rooms observed; failed to follow sanitary oxygen administration for two residents (#106, #230) of fifty-six residents reviewed; and failed to serve food in a sanitary manner. The findings included: Observation and interview with Unit Manager #1 on June 11, 2013, from 4:55 p.m. until 5:15 p.m., of Wing 1 north, middle, and south shower rooms, revealed a black substance on the tile and grout around the bottom of the shower stall area. The Unit Manager confirmed the substance "looks like mold to me." Observation and interview with Unit Manager #2 on June 11, 2013, from 5:06 p.m. until 5:09 p.m., of Wing 4 east and west shower rooms, revealed a black substance on the tile and grout around the bottom of the shower stall area. The Unit Manager confirmed the shower room had black debris. Observation and interview with Registered Nurse (RN) #1 on June 11, 2013, at 5:00 p.m., of the Wing 3 shower room revealed black debris on the edge of the shower wall and floor. The RN confirmed the black debris on the edge of the shower wall and floor. Resident #106 was admitted to the facility on July	{F 441}	room and resident care areas one day a week for 4 weeks or until substantial compliance is achieved. Results will be reported to the DON upon completion of observations. 4. Beginning Aug 2013, the DON will report to the QAPI committee monitoring outcomes concerning environmental cleaning, changing O2 tubing and humidifiers, and hand hygiene.	

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{F 441}	Continued From page 29 14, 2006, with diagnoses of Diabetes Mellitus, Hyperlipidemia, Alzheimer's Disease, Dementia, Anxiety Disorder, Depression, and Bipolar Disorder. Review of facility policy: Oxygen Concentration, revised April 23, 2008, revealed "...change disposable bubble humidifier and tubing every 7 days, label and date..." Observation on June 10, 2013, at 10:13 a.m., revealed resident #106 in the room with oxygen flowing at 2 liters per nasal cannula. Continued observation revealed a disposable bubble humidifier and nasal cannula tubing without a label containing a date when changed. Interview with LPN # 1 , on June 10, 2013, in the resident's room at 10:15 a.m., confirmed the tubing and humidifier were without a label containing a date when changed. Resident #230 was admitted to the facility on June 3, 2013, with diagnoses of Pneumonia, Septicemia, End Stage Renal Disease, Renal Dialysis Status, Uncontrolled Diabetes Mellitus, Unstageable Pressure Ulcer, Paralysis Agitans, Mental Disorder, Pneumothorax, Hypertension, Coronary Artery Disease, Ischemic Cardiomyopathy, Atrial Fibrillation, Asthma, Peripheral Vascular Disease, and Gastric Reflux Disease. Observation on June 10, 2013, at 10:13 a.m., revealed resident #106 in the room with oxygen flowing at 2 liters per nasal cannula. Further observation revealed a disposable bubble humidifier and nasal cannula tubing without a	{F 441}		

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(F 441)	Continued From page 30 label containing a date when changed last. Interview with LPN #2 ,on June 10, 2013, in the resident's room at 10:40 a.m., confirmed the tubing and humidifier did not have a label containing a date when changed last. Observation of Wing I, on June 10, 2013, from 11:45 a.m. until 12:10 p.m., revealed the Care Assistant Technician (CAT) #1 placed clothing protectors on twenty-four residents, removed one resident's hat and rubbed his head, scratched self on ear, and passed six dinner trays, without washing hands. Interview with CAT #1, on June 10, 2013, at 12:33 p.m., at the Wing 1 Nurse's station, confirmed CAT #1 had failed to wash hands between the resident contact, touching self, and prior to passing the dinner trays.	(F 441)		
(F 490) SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, review of manufacturer's instructions, observations, and interview, the facility administration failed to provide an effective system to ensure supervision and an environment free of accident hazards. The facility's failure	(F 490)	Resident # 134, # 37, #58, #71, #95, #111, #52, #193, #2, #18 and #13 1. On 6/25/13, the Administrator, Medical Director, and DON reviewed and approved all the new and revised policies and procedures. (B,C,D,E) On 6/22/13, the Administrator engaged an outside consultant to assist with the development of the action plan and the implementation of the plan. On 6/25/13, the Administrator reviewed the deficiencies with the Governing Body. On 6/25/13, the Administrator had previously approved two nurse managers to attend the 6/25/13 QAPI training session conducted by QIO in Knoxville, TN. (See attachment (O).	07/15/13

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{F 490}	Continued From page 31 resulted in multiple falls and placed four residents (#134, #37,#71, #58) in Immediate Jeopardy (a situation in which the provider's noncompliance has caused, or is likely to cause serious injury, harm, impairment, or death) of eighteen residents reviewed. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls in Immediate Jeopardy. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 8- 9, 2013, revealed the corrective actions implemented removed the Immediate Jeopardy on June 29, 2013. Non- compliance for F-490 continues at an "E" level citation. Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation and interview with front line staff and administrative staff. The facility provided evidence of new policies and procedures related to Accidents and Supervision, Chair and Bed alarms; the System Improvement Report and review of evidence the Medical Director and Administrator had reviewed and approved all policies and procedures. Inservice and training records including sign-in sheets for all nursing and non nursing staff related to the new policies and procedures were provided. Interviews with nursing staff revealed nurses and certified nursing assistants were following the	{F 490}	2. On 6/25/13, the Administrator and DON revised the QA plan and developed a standardized agenda and trending reports (J) for monitoring Incidents, Accidents, Infection Control, Restraints, Medication Errors, and Resident alarms. A called QAPI meeting was conducted 6/25/13 to approve the plan, revised policies (J) and review established tools for monitoring. The Administrator reviewed the allegations of compliance plan for the IJ tags received during the recent survey at this meeting. The Administrator will attend QAPI meetings and receive reports for review to ensure compliance and the information from QAPI trends reports will be communicated to Governing Body by the Administrator. 3. On 6/25/13 and 7/15/13, the DON, ADON and/or QAPI Coordinator will monitor falls and fall interventions, alarms, notification of Physician of lab results, changing O2 tubing and humidifiers timely and with dates, hand hygiene in dining and resident care areas, administering medications timely, medication administered when allergy present, accurate MDS assessments and careplans, dignity in delivery of trays, placing of clothing protectors, restraints, and reporting incidents of unknown origin to State. The DON and/or Clinical Managers will monitor performance of staff on a monthly basis for 90 days concerning falls intervention, compliance with revised falls prevention program. This began on 6/25/13. Beginning 6/25/13 the Administrator will ensure the daily/weekly/ monthly monitoring is occurring as stated for compliance of deficiencies and report finds to QAPI committee and governing body.	

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{F 490}	Continued From page 32 new policy and procedure related to the new fall and prevention policy, and alarm policy. Interview with the Administrator revealed the Administrator met with the Governing Body members to discuss the status of the survey. Interview and documentation review with the Administrator revealed with help of an outside consultant the Administrator and the Director of Nursing developed a standardized agenda and trending reports for monitoring falls and alarms. The facility will remain out of compliance at a Scope and Severity level "E"- a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate Jeopardy, until it provides an acceptable plan of correction and the facility's corrective measurers could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.	{F 490}	4. Beginning 6/25/13 the Administrator will conduct timely QAPI meetings quarterly and will also conduct these meetings more often if needed to evaluate compliance with policies and procedures as well as the monitoring tools established. The Administrator will report to the governing body.	
{F 501} SS=E	483.75(l) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, review of manufacturer's instructions, observation, and interview, the Medical Director failed to provide oversight and participate in the	{F 501}	Resident # 134, # 37, #58, #71, #95, #111, #52, #193, #2, #18 and#13 1. The Medical Director reviewed the treatment plans and falls interventions of each resident on 6/25/18 for effectiveness and any needed changes to their plan of care. This was recorded in the progress note of each resident. Beginning on 6/24/13, the DON, Administrator, and Medical Director reviewed and revised the policies and procedures as follows: Falls Prevention Program with forms and Chair and Bed Alarm. On 6/24/13, the Healthcare Consultant reviewed the Federal and State responsibilities required for the Medical Director with the DON, Administrator, and Medical Director.	07/15/13

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{F 501}	Continued From page 33 development of policies and procedures to ensure an effective system for supervision of residents at risk for falls. The facility's failure placed four residents (#134, #37, #58, #71) in Immediate Jeopardy (a situation in which the provider's noncompliance has caused, or is likely to cause serious injury, harm, impairment, or death) of eighteen residents reviewed for falls. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls in Immediate Jeopardy. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 8- 9, 2013, revealed the corrective actions implemented removed the Immediate Jeopardy on June 29, 2013. Non- compliance for F-501 continues at an "E" level citation. Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation and interview with front line staff and administrative staff. The facility provided evidence of new policies and procedures related to Accidents and Supervision, Chair and Bed alarms, the System Improvement Report and review of evidence the Medical Director and Administrator had reviewed and approved all policies and procedures. The Medical Director reviewed treatment plans and fall interventions for each resident. Inservice and	{F 501}	2. On 6/25/13, the DON, ADON, Clinical Managers and Staff Development Nurse reviewed the medical records of all residents with falls for the past 45 days to ensure correct interventions were in place. There were new clarified interventions implemented on three residents and put on care plans. PT/OT screened each resident at the time of each fall and evaluations, treatment, or intervention were put into place. The DON reviewed the outcomes of these reviews with the Medical Director. On 6/25/13, the DON, ADON and Clinical Managers assessed all residents with alarms using the new Assessment for Assistive Device. Eleven alarms were removed based on the outcomes of the assessments. Due to resident level of functioning, alarms no longer required and/or no falls within past 90 days. This was reviewed with the Medical Director. All devices were tested for functionality by ADON, chair and bed alarm policy C) were put into place, assessment of assistive device (E) and alarm check forms (D). On 6/24/13 and 6/25/13, the DON and/or Staff Development Nurse conducted mandatory in-services for all nursing staff concerning revised fall prevention program with changed forms, chair and bed alarm. Any RN, LPN or CNA not attending mandatory in-services will not be allowed to work until they have attended the in-service. All employees will complete a post-test following the in-service within 7 days administered by Staff Development Nurse and/or Clinical Managers.	

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{F 501}	Continued From page 34 training records including sign-in sheets for all nursing and non nursing staff related to the new policies and procedures were provided. Interviews with nursing staff revealed nurses and certified nursing assistants were following the new policy and procedure related to the new fall and prevention policy, and alarm policy. The facility will remain out of compliance at a Scope and Severity level "E"-a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.	{F 501}	3. Beginning on 6/25/13, the Administrator will monitor Medical Director's attendance at the QAPI committee and that signatures are obtained on the reports submitted for review. On 6/25/13, the DON implemented the monitoring tools approved by the Medical Director and Administrator necessary to monitor alarms, restraints, falls interventions, Notification of Physician of lab results, changing 02 tubing and humidifiers timely, medication administered when allergy present, accurate MDS assessments and careplans, dignity of delivery of trays, placing of clothing protectors, restraints and reporting incidents of unknown origin to State.	
{F 505} SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician of lab results timely for one resident (#134) of fifty-six residents reviewed. The findings included: Resident #134 was admitted to the facility on June 17, 2008, with diagnoses including Anxiety, Depressive Psychosis, and readmitted August 13, 2013, with diagnoses including right femur	{F 505}		

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{F 501}	Continued From page 34 training records including sign-in sheets for all nursing and non nursing staff related to the new policies and procedures were provided. Interviews with nursing staff revealed nurses and certified nursing assistants were following the new policy and procedure related to the new fall and prevention policy, and alarm policy. The facility will remain out of compliance at a Scope and Severity level "E"-a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate Jeopardy, until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.	{F 501}	4. Beginning 6/25/13, the Administrator will conduct meetings timely, ensure all members attend meetings 100% of the time with any absences approved prior to meeting and that all monitoring reports are completed in a timely manner for each meeting by all respective managers. The Administrator will report to the governing body concerning these monitoring outcomes on a quarterly basis or more often as necessary. Attachment: List of residents who were assessed and the ones with alarms removed. (N)	
{F 505} SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician of lab results timely for one resident (#134) of fifty-six residents reviewed. The findings included: Resident #134 was admitted to the facility on June 17, 2009, with diagnoses including Anxiety, Depressive Psychosis, and readmitted August 13, 2013, with diagnoses including right femur	{F 505}	Resident #134 1. On 7/12/13 the DON/Staff Development Nurse conducted an in-service with licensed nurses concerning notification of physician of any lab results upon receiving reports. (Q) Nursing staff will be in-serviced upon return to work and ongoing by DON/ADON/Staff Development Nurse. A post-test will be conducted by the Staff Development nurse beginning 7/15/13. 2. On 7/1/13, the Clinical Managers checked lab reports for the past week for timely notification of physician/NP of the results and documented. No resident had lab results that were not reported.	07/15/13

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{F 505}	Continued From page 35 fracture. Medical record review of a Laboratory Result of a Urine Culture (collection date July 6, 2013) revealed "...Organism...probable proteus..." Medical record of a Nurse's Note dated July 8, 2012, at 10:05 a.m., revealed "...urine culture report noted and placed in the NP (nurse practitioner) book for further review." Medical record review of a Nurse's Note dated July 9, 2013, at 4:00 p.m., revealed "...Urine C&S (culture and sensitivity) called to Dr. (doctor)...T.O. (telephone order) Ampicillin (antibiotic) 500 mg (milligram) QID (four times per day) x (times) 5 days...placed on MAR (medication administration record), faxed to pharmacy..." Interview with Unit Manager #3 on June 13, 2013, at 2:30 p.m., in the conference room revealed the culture report was placed in the NP book. Continued interview revealed the NP visited the facility and checked the book Monday through Friday. Further interview revealed the results had been placed in the book on Friday and the NP did not respond. Interview with the Director of Nursing on June 13, 2013, at 2:35 p.m., in the conference room confirmed the facility had failed to notify the Physician timely of a Urine C&S resulting in a delay in treatment.	{F 505}	3. Beginning 7/15/13, the Clinical Managers and Weekend Supervisor will review communications book to MD/NP daily to ensure compliance of notification of physician/NP. Outcomes will be reported to DON at the morning meeting per policy (Q). Each charge nurse will continue to note daily on the 24 hour Nursing Report resident change of condition and MD/NP orders, including lab reports. 4. Beginning Aug 2013, the DON will report monitoring outcomes concerning notification of lab results to the QAPI committee beginning with the scheduled 8/14/13 QAPI meeting. The Administrator will report to the governing body concerning these monitoring outcomes on a quarterly basis or more often as necessary.	
{F 520} SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	{F 520}		

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(F 520)	Continued From page 36 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the facility Quality Assurance (QA) Committee, facility investigation reviews, facility policy reviews, observations, and interviews, the facility failed to ensure the Quality Assurance Committee identified resident's safety, alarm use and falls as potential areas for quality improvement. The facility's failure to review data and formulate/implement improvement plans placed four resident's (#37, #58, #71, and #134), in	(F 520)	Resident # 134, # 37, #58, #71, #95, #111, #52, #193, #2, #18 and #13 1) The DON, Administrator, and Medical Director reviewed and revised the QAPI Plan (J) and presented the Plan (J) at a called meeting on 6/25/13 of the QAPI meeting and developed a standardized Agenda (J) and minute format (J) to ensure all topics and reports are reviewed and addressed on a quarterly basis. The following are members of the QAPI committee: Administrator, DON, ADON, Social Services Director, Business Office Manager, Clinical Managers, Activities Director, Dietary Manager, Rehab Director, Pharmacy Consultant, Maintenance Director, and Medical Director. Attachment: QAPI Plan, Trending Reports, and quality indicators.(J) The DON & Administrator developed monitoring tools for Falls, Alarms, and careplans to ensure safety of all residents in facility. The monitoring tools for falls (B) will be completed by the ADON and /or Clinical Managers daily and will be provided to the DON to compile an analysis to present to QAPI. A checklist for falls, skin tears, and bruises was developed for licensed nurses to use to ensure all information is completed at time of fall. Four incident logs were revised into one to ensure tracking and completion of investigation. Fall rosters were developed to aid the Charge Nurses in tracking interventions on each resident. The ADON ensures the section on notification of the physician is always completed on the incident form.	07/15/13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445141	A. BUILDING _____ B. WING _____	R 07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(F 520)	Continued From page 37 Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) of eighteen residents reviewed. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls in Immediate Jeopardy. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 8- 9, 2013, revealed the corrective actions implemented removed the Immediate Jeopardy on June 29, 2013. Non- compliance for F-520 continues at an "E" level citation. Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation and interview with front line staff and administrative staff. The facility provided evidence of new policies and procedures related to Accidents and Supervision, Chair and Bed alarms, the System Improvement Report and review of evidence the Medical Director and Administrator had reviewed and approved all policies and procedures. Inservice and training records including sign-in sheets for all nursing and non nursing staff related to the new policies and procedures were provided. Interviews with nursing staff revealed nurses and certified nursing assistants were following the	{F 520}	The monitoring tools for alarms will be completed by the CNAs daily and will be provided to the DON to compile an analysis to present to QAPI. A copy of the care plan is attached to every fall incident for ADON to review and to ensure that interventions have been added to the care plan. Attachment: Checklists (B). incident log, Alarm checklist (D), Falls intervention roster (K). 2) On 6/25/13 the Administrator, with consultation of a Healthcare Consultant, conducted a Department Head meeting to review new QAPI plan, agenda, and monitoring parameters methodology for collecting and analyzing data. On 6/25/13 the Administrator developed Quality Improvement Objectives for 2013 to be presented at the July QAPI committee meeting and the July Board meeting. Attachment: 2013 Objectives (L) All staff will report to their respective Department Head to communicate observed problems or concerns. 3) Beginning 6/25/13 the Administrator will conduct timely QAPI Committee meetings monthly, and more often if necessary, to ensure the quality of care is monitored and complies with the standard of care. Beginning 6/25/13, the Administrator will ensure the Monitoring and Trending Reports for falls, alarms, careplans, incident reports, Incident/Accidents, Infections Control, Reportable Events and Environment of care, timely processing of physician orders, hand hygiene, food	

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(F 520)	Continued From page 38 new policy and procedure related to the new fall and prevention policy and alarm policy. A Quality Assurance meeting was held on June 26, 2013 where the Administrator and Director of Nursing presented a new standardized agenda to ensure all topics and reports will be reviewed quarterly. The Administrator and Director of Nursing developed monitoring tools for falls, alarms, and care plans to ensure safety of all residents. The facility obtained an outside Healthcare Consultant and along with the Administrator conducted a Department Head meeting to review the new Quality Assurance Plan, agenda and monitoring parameters methodology for collecting and analyzing data. The facility will remain out of compliance at a Scope and Severity level "E"-a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate Jeopardy, until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.	(F 520)	temperature, medication administration, allergy noted, protective coverings during meals, are all completed. 4) Beginning 6/25/13, the Administrator will conduct meetings timely, ensure all members attend meetings 100% of the time with any absences approved prior to meeting and that all monitoring tools are completed in a timely manner for each meeting by all respective managers. Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's creditible allegation of compliance.	